

TEACHING AND LEARNING ETHICS

Moral theories may have some role in teaching applied ethics

D Benatar

J Med Ethics 2007;33:671–672. doi: 10.1136/jme.2007.022137

In a recent paper, Rob Lawlor argues that moral theories should not be taught in courses on applied ethics. The author contends that Dr Lawlor's arguments overlook at least two important roles that some attention to ethical theories may play in practical ethics courses. The conclusion is not that moral theory *must* be taught, but rather that there is more to be said for it than Dr Lawlor's arguments reveal.

In a recent article¹ in the *Journal of Medical Ethics*, Rob Lawlor argues that moral theories should not be taught in courses on applied ethics, including medical ethics. He provides two sets of arguments for his conclusion.

The first set is practical. He observes that moral theories are complex and that the time available in applied ethics courses, particularly those aimed at professionals or future professionals, is often limited. As a result, he argues, one of two problems is likely to arise if one tries to teach moral theories. Either one will probe the theories in depth, in which case students will not comprehend what one says, or one will cover the theories superficially, in which case students will understand, but what they will have understood will be only a caricature of the theories. One possible consequence of caricaturing moral theories, Dr Lawlor says, is that students will dismiss them as "obviously wrong and ridiculous".

The second set of arguments is methodological. Here Dr Lawlor argues that the "attempt to construct a moral theory that offers a foundational justification for all our moral judgements is a far more ambitious project than the attempt to answer particular questions". Moreover, we "have much more confidence in our judgements about which particular pro tanto duties we have than we have in our judgements about which moral theory is correct." Thus, he says, we should not think that we need to construct a moral theory before we can grapple with particular moral problems.

Much of what Dr Lawlor says is true, but whether his arguments succeed depends on exactly what his conclusion is. In the final section of his paper, he concedes that moral theories need not be avoided entirely. He agrees that students should at least be familiar with terms like "utilitarianism" and "deontology". It is clear, then, that Dr Lawlor is opposed to the *teaching* of moral theories and that he is not opposed to *mentioning* them. What is less clear is how much talk about theories he thinks is compatible with his arguments—or, in other words, how much talk about theories constitutes "teaching theories". He appears to think that no more than very little talk about theories is compatible with his arguments.

If that is the case, then I think that Dr Lawlor has overlooked an important role that *some* attention to moral theories can serve in the teaching of bioethics and other applied ethics. If, by contrast, Dr Lawlor thinks that his arguments do *not* preclude the kind of attention to ethical theory that I shall defend, there is nonetheless some value in my defending a limited role for ethical theory in practical ethics courses. This is because his readers might interpret him otherwise.

One reason why some discussion of moral theories may be important is that non-philosophers, often without realising it, appeal to theoretical frameworks when discussing practical moral problems. Such unwitting appeals to moral relativism, religious theories of ethics, utilitarianism, deontology and other theories are extremely common. Consider one example. Many ordinary defenders of a legal right to abortion argue that abortion should be legal because criminalising it leads to "back-street abortions" and the associated increased maternal mortality and morbidity. If students are introduced to moral theories, they will be able to identify this as a consequentialist argument. They will know that sophisticated consequentialists would not be content with so unrefined an argument. Finally, they will be aware that, in any event, the whole consequentialist approach is not uncontested. Thus, to attempt to answer a practical moral question by appealing to a single theory is unlikely to be convincing to those who reject the theory.

The value of discussing the theories, therefore, is not to lay a theoretical foundation that is then applied to practical problems. Instead it is precisely the opposite—to expose theoretical assumptions and to show how they are more controversial than those who naively articulate them in lay moral discussions may realise. This does not require probing the theories in a depth that students cannot grasp. However, neither does it mean reducing the theories to caricatures. The latter problem is avoided by (no more than) gesturing at the sophistication of moral theory. By providing even limited insight into its complexity, one can caution against a natural tendency to superficiality in ordinary thinking about practical moral problems.

This approach also pre-empts another problem that Dr Lawlor thinks one risks in teaching moral theory in applied ethics courses. That is the problem of students' adopting a crude form of relativism in which the answers to moral questions are relative to moral theories and one may choose whichever theory one prefers. This error is forestalled partly because one does not present moral theory as a means to answering practical moral problems. But other factors also play a role. If

Correspondence to:
D Benatar, Philosophy
Department, University of
Cape Town, Private Bag X3,
Rondebosch 7701, South
Africa; David.Benatar@uct.
ac.za

Received 30 June 2007
Accepted 3 July 2007

theory is discussed in the way I am suggesting, students should be aware that while they have learnt enough to know that appeal to a single theory will be inadequate to resolve a practical problem, they do *not* know enough to choose among the theories. Students can be taught the important lesson, relevant to both theory and practice, that just because there is a disagreement—even an unresolved one—this does not mean that every view is correct.

A second reason why it may sometimes be helpful to have some discussion of moral theories before turning to practical moral problems is that students often hold much stronger opinions about practical issues than they do about theoretical ones. A discussion of theory, therefore, can introduce students to philosophical reasoning via issues about which students may

be less defensive and more open-minded. The skills, even if not the theories, can then be applied and developed further in the discussion of practical problems.

Dr Lawlor is entirely correct that moral theorising has limited value in resolving practical moral problems. However, that does not suffice to preclude some teaching about moral theory in courses about practical ethics. I have not argued that moral theory *must* be taught, but rather that there is more to be said for it than Dr Lawlor's arguments reveal.

Competing interests: None declared.

REFERENCE

- 1 Lawlor R. Moral theories in teaching applied ethics. *J Med Ethics* 2007;**33**:370–2.

BMJ Clinical Evidence—Call for contributors

BMJ Clinical Evidence is a continuously updated evidence-based journal available worldwide on the internet which publishes commissioned systematic reviews. *BMJ Clinical Evidence* needs to recruit new contributors. Contributors are healthcare professionals or epidemiologists with experience in evidence-based medicine, with the ability to write in a concise and structured way and relevant clinical expertise.

Areas for which we are currently seeking contributors:

- Secondary prevention of ischaemic cardiac events
 - Acute myocardial infarction
 - MRSA (treatment)
 - Bacterial conjunctivitis
- However, we are always looking for contributors, so do not let this list discourage you.

Being a contributor involves:

- Selecting from a validated, screened search (performed by in-house Information Specialists) valid studies for inclusion.
- Documenting your decisions about which studies to include on an inclusion and exclusion form, which we will publish.
- Writing the text to a highly structured template (about 1500–3000 words), using evidence from the final studies chosen, within 8–10 weeks of receiving the literature search.
- Working with *BMJ Clinical Evidence* editors to ensure that the final text meets quality and style standards.
- Updating the text every 12 months using any new, sound evidence that becomes available. The *BMJ Clinical Evidence* in-house team will conduct the searches for contributors; your task is to filter out high quality studies and incorporate them into the existing text.
- To expand the review to include a new question about once every 12 months.

In return, contributors will see their work published in a highly-rewarded peer-reviewed international medical journal. They also receive a small honorarium for their efforts.

If you would like to become a contributor for *BMJ Clinical Evidence* or require more information about what this involves please send your contact details and a copy of your CV, clearly stating the clinical area you are interested in, to CECommissioning@bmjgroup.com.

Call for peer reviewers

BMJ Clinical Evidence also needs to recruit new peer reviewers specifically with an interest in the clinical areas stated above, and also others related to general practice. Peer reviewers are healthcare professionals or epidemiologists with experience in evidence-based medicine. As a peer reviewer you would be asked for your views on the clinical relevance, validity and accessibility of specific reviews within the journal, and their usefulness to the intended audience (international generalists and healthcare professionals, possibly with limited statistical knowledge). Reviews are usually 1500–3000 words in length and we would ask you to review between 2–5 systematic reviews per year. The peer review process takes place throughout the year, and our turnaround time for each review is 10–14 days. In return peer reviewers receive free access to *BMJ Clinical Evidence* for 3 months for each review.

If you are interested in becoming a peer reviewer for *BMJ Clinical Evidence*, please complete the peer review questionnaire at www.clinicalevidence.com/ceweb/contribute/peerreviewer.jsp